Healthpoint

Information from the Massachusetts Rate Setting Commission

Massachusetts
Rate Setting Commission

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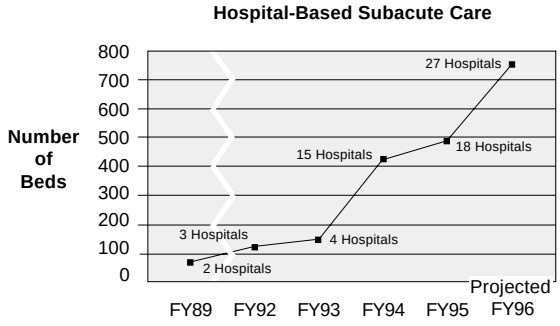
Welcome to the second issue of *Healthpoint.*

This is the *second edition* of a new quarterly publication combining both the data and analytic resources of the Massachusetts Rate Setting Commission. Each *Healthpoint* will update trends of general interest and present a treatment of a health policy issue of current importance to policy makers in the Commonwealth. We would like to know what you would like to know. Please send your comments and suggestions for future policy topics to the Rate Setting Commission's Office of Communications: (617) 451-5310 (voice) or (617) 451-1878 (fax).

COMPETITION HEATS UP: HOSPITAL SUBACUTE CARE UNITS ON THE RISE

As the competitive health care market drives the trend toward greater integration of care, hospital-based subacute care is expanding rapidly. In hospitals and other settings, the development of subacute care is motivated largely by a desire for cost control and by reimbursement incentives. Important questions—Is it good care? Does it save money? Under what circumstances?—are still unanswered. This issue of Healthpoint discusses the origin and evolution of subacute care and what incentives have drawn hospitals increasingly into the market. We also pose some of the policy questions—concerning where this care is best provided, to whom and at what cost—that warrant attention in this expanding segment of the health care system.



What is Subacute Care?

Subacute care—skilled, post-hospital care for patients with complex needs—grew in the 1980s as a response to the new Medicare Prospective Payment System, which encouraged hospitals to reduce lengths of stay for acute services. Subacute care provides patients a transition from the acute hospital to less intensive settings. Traditionally, such care has been delivered outside of acute hospitals—in rehabilitation hospitals, skilled nursing facilities, or by home health providers.

Recently, the concept of subacute care is evolving toward something more specialized, and acute hospitals are entering the market in increasing numbers. The prototypical subacute care is delivered in an organized program at a distinct site, and is centered on specific interventions, such as pain management, or on specific diseases, such as stroke. A program may also require special resources, such as more highly trained physicians and nurses than those found in a traditional post-acute facility, and employ specialized techniques like the use of interdisciplinary teams, case managers, critical pathway protocols, evaluation based on measured outcomes and continuous quality improvement.

Some see these characteristics as representing the ideal, though few providers have thus far realized it. There remains, however, the potential for the "new" subacute care to bring added value to the health care system.

The Massachusetts Market for Hospital-Based Subacute Care

Currently in Massachusetts 18 acute hospitals report operating subacute care units within the hospital (others own freestanding subacute facilities). These in-hospital units account for 482 beds. An additional nine hospitals intend to open 276 more subacute care beds. (See the chart on page 1.)

Why have acute hospitals found subacute care increasingly attractive? A number of factors influence the trend.

Highest Volume Hospital-Based Skilled Nursing (Subacute) Units

Beverly (Beverly)
Symmes (Arlington)
Saints Memorial (Lowell)
Medical Center of Central Mass. (Worcester)
Deaconess (Boston)

Source: Mass. Rate Setting Commission RSC-403

Compensation for declining inpatient business. The number of inpatient days in Massachusetts acute hospitals has fallen since 1990 by over 30 percent. One strategy for using excess capacity and thereby shoring up revenues is to provide different levels of care. In 1995, the 18 hospital-based subacute units delivered 125,000 patient days of care, equivalent to 13 percent of their inpatient volume. The average length of stay in these units ranged from 11 to 24 days, and total charges for these services were approximately $83 million.

Managed care. The high penetration of managed care in the state and the anticipation of more managed care for Medicare patients (Medicare patients account for 89 percent of the care provided in hospital-based subacute care units) influences the proliferation of these units as well. As health plans move toward more inclusive payment arrangements such as capitation, hospitals make themselves more attractive contracting partners if they provide a full range of care within their own integrated systems. A hospital-based subacute unit is thus a marketing point for hospitals seeking contracts with managed care plans.

Medicare reimbursement. Hospital-based subacute units developed partly in response to the advent of the Medicare prospective payment system for inpatient care. Acute inpatient care is subject to preset payment amounts for each Medicare admission. This creates an incentive to shorten lengths of stay, which is made more feasible if transitional care is available. During the first two years of a subacute unit's operation Medicare reimburses a hospital (usually more generously) on a cost basis for stays up to 100 days following an inpatient stay of at least three days. In subsequent years, Medicare reimbursement is still cost-based, but subject to a yearly inflation limit.

The Health Care Finance Administration (HCFA) announced this year that only those subacute units with a state-approved Determination of Need (DoN) are eligible for cost-based reimbursement from Medicare for the first two years. Only some of the new hospital subacute beds have a DoN; the remainder have been purchased from nursing homes and therefore must make do with less generous reimbursement while competing with less costly facilities. There is excess capacity in the

system, reflected in the large number of beds approved but not yet licensed and in the below-maximum occupancy of skilled nursing facilities, and the Department of Public Health has issued a moratorium on further DoN for skilled nursing services.

Nevertheless, Massachusetts hospitals still find a financial benefit to purchasing beds and opening subacute units in the face of declining inpatient revenue. This benefit may be short-lived, as more Medicare patients enroll in managed care. HMOs may choose to direct patients to less costly subacute care in freestanding nursing facilities, a viable alternative given the available capacity. In addition, the American Health Care Association is studying the feasibility of designing a prospective payment system, like that now in place for Medicare acute hospital admissions, for subacute care. The long-term picture for subacute care in hospitals may therefore not be so optimistic.

Cost-Effectiveness and Quality of Care Issues

A number of forces converge to make opening a subacute unit a logical choice for many acute hospitals. As Costs differ so dramatically across the different sites of care—$131 per day on average in freestanding nursing facilities versus $454 in hospital-based units—it is important to have a way to evaluate whether patients are receiving care in the right places and for the right reasons.

Few studies have been able to determine the cost-effectiveness of subacute care. One major study on the potential cost savings to the Medicare program (conducted by Abt Associates for the American Health Care Association) projected, under various policy options (for example, waiving the minimum hospital stay necessary for admittance to a subacute care program) a range of potential savings from $225 million to almost $9 billion. The study made several assumptions that may not be substantiated, though, so the potential for savings is still very unclear. More research is required on this issue.

Similarly, there is little information about the quality of subacute care at different sites where it is delivered. There have been attempts to measure quality using, for example, the Functional Independence Measure, a well-established measure of outcomes for rehabilitation patients. There are also various measures in development for complex medical patients. An experiment now underway in Illinois seeks to compare both the costs and the outcomes for patients treated in hospital-based versus freestanding subacute facilities. Illinois is studying whether its Medicaid program should create a separate reimbursement category for subacute care, and which setting is most appropriate for its delivery.

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Subacute care may become an area of intense competition among different types of providers—acute hospitals, chronic/rehabilitation hospitals, freestanding skilled nursing facilities and home health providers. For acute hospitals, whose inpatient business has been dropping steadily over the past several years, the introduction of hospital-based subacute units may be one way of gaining back revenue. The high concentration of managed care in the state, the incentives of the reimbursement system, and the formation of integrated delivery systems (originating, for the most part, in acute hospitals) have fostered the emergence of these units.

Given the various settings for the provision of subacute care, and the potential impact of this competition on some providers' financial viability, more information would be useful to answer broad policy questions of financing and delivery:

What is the relative cost-effectiveness of subacute care provided in different settings?

Cost analyses to date have concentrated on differences in cost per day or in direct resource consumption between acute and non-acute settings. Decision makers should also know the effect of subacute care on the cost of an entire episode of care, as well as the effect of subacute care on long term outcomes for patients.

In what circumstances is subacute care most appropriate for the patient?

Hospitals want to transfer patients they discharge from acute care to their own subacute units, even if their capacity is taxed and there are available beds in a nearby freestanding facility. Apart from these financial imperatives, more information is needed to determine for which types of patients subacute care is most beneficial, and in what setting. Do only certain types of patients benefit from the substitution of a subacute care stay for additional days in an acute hospital? Do some patients benefit more than others and why?

What is the most effective care?

Finally, as with other segments of the health care system, there is a need for reliable indicators of the quality of care, particularly in comparison to alternative treatments and settings. Patients, clinicians, payers and policy makers should all benefit from information on the relative value of the many options for this type of care.

Further Reading

1. Subacute Care: Policy Synthesis and Market Area Analysis, Lewin-VHI, Inc. (November 1,1995).
2. "What's New in Subacute Care?", Modern Healthcare (January 22, 1996).
3. "Is Subacute Care Worth Your Money?", Business & Health (July, 1995).
4. "Sorting Out Subacute Care", Modern Healthcare (April 25, 1994).

Did you know?

Hospital Facts

	Massachusetts FY96 Data Submitted to Date	Massachusetts Comparable FY95 Data	Massachusetts FY95	Massachusetts FY94	Massachusetts FY90	U.S. FY94	California FY94
Number of Hospitals							
Acute	83	83	83	87	92	5,229	427
Non-Acute	56	56	56	54	65	811	60
Number of Acute Hospital Discharges (thousands)	137	144	783	823	895	30,718	3,021
Number of Acute Hospital Discharges/1,000 population	***	***	131	137	153	118	94
Number of Acute Hospital Days/1,000 population	***	***	705	766	1,046	796	529
Acute Hospital Length of Stay	5.58	5.32	5.35	5.68	6.82	6.70	5.60
Percent Inpatient Hospital Revenues	N/A	N/A	60%	64%	72%	72%	75%
Percent Outpatient Hospital Revenues	N/A	N/A	40%	36%	28%	28%	25%

HMO Facts

	Massachusetts 1996	Massachusetts 1995	Massachusetts Change	U.S. 1996	U.S. 1995	U.S. Change
HMO Premium (large group, single, including R_X)	$ 178.07	$ 178.77	- 0.4%	$ 156.74	$ 161.68	- 3.1%
	1995	**1994**	**Change**	**1995**	**1994**	**Change**
Operating Margin	-2.9%	0.02%	- 3.1%	n/a	n/a	n/a
Required Revenue per Member per Month	$ 158.39	$ 157.39	0.6%	$ 131.98	$ 136.51	- 3.3%
Medical Cost per Member per Month	$ 138.91	$ 145.08	- 4.3%	$ 114.16	$ 117.37	- 2.7%
Total Members	2,467,177	2,279,725	8.2%	53,354,526	47,253,263	12.9%
Percentage of Population	40.6%	37.7%	7.6%	20.3%	18.1%	11.9%
Medicare Members	93,751	72,811	28.8%	n/a	n/a	n/a
Medicaid Members	87,627	94,007	- 6.8%	n/a	n/a	n/a

Sources: Massachusetts Rate Setting Commission (MRSC); *Hospital Statistics - 1994/95* (American Hospital Association); MRSC calculations based on Massachusetts Division of Insurance, HMO Rate Filings, Quarterly Statements & NAIC Annual Statements; Milliman & Robertson, 1994 & 1995 HMO Intercompany Rate Surveys; InterStudy Publications, 1994 & 1995 HMO Enrollment (U.S. figures); U.S. Bureau of the Census

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